ADVANCE CARE PLANNING IN COPD

Some specific disease related indicators of poor prognosis – NOT to be taken in isolation:

- Dependent for more than 3 Activities of Daily Living
- Severe airways obstruction (FEV1 <30%) or restrictive deficit (vital capacity <60%, transfer factor <40%)
- Meets criteria for long term oxygen therapy; persistent hypoxia (PaO2 <7.3kPa)
- Breathlessness at rest or on minimal exertion between exacerbations
- Refractory symptoms despite optimal tolerated therapy
- Symptomatic right heart failure
- Cachexia; low BMI (<21)
- Comorbidity conferring a poor prognosis
- Increased emergency admissions for infective exacerbations and/or respiratory failure / increased frequency of exacerbations

Step 1: Identify possible patients for supportive and palliative care

“Would it surprise me if this patient dies within 1 year?”

Step 2: Optimisation of treatment

Close working with the respiratory team - refer via CICS to COPD services for optimisation / consideration of new treatment options if not already known and appropriate

Step 3: Initiation of discussions

- Identify triggers for discussion
- Open, honest communication with patient +/- carer of unpredictable prognosis and if a clinical deterioration +/- palliative status
- Begin discussions surrounding preferred place of care and death
- Discuss and document CPR/DNAR status
- Liaison with Community Respiratory Team – organise joint meetings with patient where appropriate
- Primary Care management of general symptom control
- Refer to local specialist palliative care services if complex needs and meets criteria

Step 4: Assessment, care planning and review

- Discuss and document care preferences – regularly review as can change over time
- Monitor psychological status
- Regular assessment and review of carer/family needs
- Document agreed treatment escalation plan – hospital admission, IV antibiotics, non-invasive ventilation, HDU, ITU
- Medication review – discontinue non-essentials
- Consent for entry onto CMC and create patient record
- Welfare review of benefits and advice
- Anticipatory prescribing

Step 5: Coordination of care and delivery of high quality services

- Ensure CMC record complete and finalised
- Use Gold Standards Framework and include patients on GP palliative registers
- Involve wider MDT and review appropriate health and social care services to meet identified patient and carer needs
- Ensure patients and carers have the opportunity at all stages of care to discuss issues of sudden death and living with uncertainty
- Symptom control and care for the dying palliative guidelines
- Access to palliative care expertise
- Local hospices

Step 6: Care in the last days of life

- Identification of the dying phase
- Priority GP visit to ensure expected deaths avoid the need for a Post Mortem
- Review needs and preferences for place of death and accommodate accordingly - may need to update CMC
- Support for patient and carer
- Consider implementing best supportive care – stop inappropriate interventions
- Medication review – discontinue non-essentials and consider alternative routes of administration NB absorption of subcutaneous medication given into oedematous tissue may be poor
- Discuss the option of sedation in the event of increasing distress
- Bereavement preparation and information for carers about certifying and registering a death

Step 7: Care after death

- Timely verification and certification of death or referral to coroner
- Bereavement support for carer and family
- Update CMC record with date and place of death
- Could use GP Gold Standards Framework meetings to reflect and review selected cases as a learning process

Support and information for patients, carers and families, including access to spiritual care services according to patient’s cultural and religious beliefs

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**GUIDELINES FOR SYMPTOM CONTROL IN ADVANCED COPD**

### GENERAL ADVICE
- Continue symptom control alongside optimised active respiratory management until such becomes inappropriate.
- Ensure patient concordance with medication.
- Treat reversible precipitants if patient deteriorates (LRTI, non-compliance, anaemia, PE, MI, arrhythmia, effusion, SVCO) as appropriate.
- MDT approach – physio, OT, social worker, spiritual care services, pharmacist.
- Seek advice from specialist palliative care.

### BREATHLESSNESS
- **Consider other causes of breathlessness** – psychological, comitont medical problems (LRTI, CCF, anaemia, PE, effusion, SVCO) and treat if/as appropriate.
- **Non-pharmacological management** – consider referral to local hospice, day therapy unit - relaxation and breathing exercises, lifestyle adjustments, psychological support, complementary therapies, handheld/bedside fan – can be more effective than oxygen if patient not hypoxic, open windows.
- **Pharmacological management** – if above measures not optimised symptoms, consider escalating COPD medication, ask for a review by the community respiratory team.
- Continue and review inhaled medications and technique; consider use of a spacer device or nebuliser.
- **Long term oxygen therapy guidelines**
  - Oxygen is only useful if the patient is hypoxic; nasal prongs may be better tolerated; a fan or changing the patient’s position can help.

### CACHEXIA AND ANOREXIA
- **Weight loss and associated muscle wasting is common**
- Exclude potentially reversible causes e.g. n/v, depression, shortness of breath, uncontrolled pain.
- **Regular assessment and referral** to dietician if indicated.
- **STOP unnecessary medications** to alleviate tablet burden.

### DRY MOUTH
- Assess for any underlying cause – oxygen, medication, PO thrush.
- Treat reversible causes.
- Suck on ice cubes, chew sugar-free gum – stimulants.
- Sip pineapple juice/suck chunks – if coated tongue.
- If ABOVE MEASURES INEFFECTIVE, BioXtragel I TOP PRN.
- Consider a nicotine replacement patch for heavy smokers.

### NAUSEA/VOMITING
- Multiple causes – consider measuring U&Es and calcium.
- Treat reversible factors - if appropriate.
- May be due to disease progression.
- Iatrogenic – discontinue precipitant medication.
- **Pharmacological management** – see pocket guide.

### MENTAL HEALTH
- **Depression** and anxiety, occurring separately or together, are common.
- **Non-pharmacological management** – explore concerns, ask about sleep, consider psychological factors – mood, meaning of disease progression, fears re future.
- MDT approach – physio, OT, social worker, spiritual care services, pharmacist.
- Pharmacological management – see pocket guide, WHO ladder and CPR.
- Give patient information leaflet if starting opiate NB morphine undergoes renal excretion, monitor closely for toxicity – frequency/dose of morphine may need to be reduced, or use of alternative opioid – seek advice from local specialist palliative care team.
- Consider prophylactic laxatives.

### DRY MOUTH
- **Cough**
  - Treat reversible causes – underlying heart failure, ACE Inhibitors (only consider stopping if persistent cough, substitute with ARB - Losartan), LRTI, effusion, oesophageal reflux.
  - Pharmacological management;
    - 1st line: Codeine Linctus 5-10ml PRN (max dose QDS, AVOID/STOP if already on an opiate).
    - 2nd line: Morphine Sulphate IR (Oromorph) (10mg/5ml) starting dose 2.5mg PO 4hrly and PRN – seek specialist advice before initiating, give patient information leaflet re opiates, titrate dose every 48hrs according to effectiveness and tolerance, monitor for opiate toxicity.
    - For patients already on a strong opioid, intolerance to morphine, or with significant renal impairment (eGFR <30mL/min or Cr >150micromol/L), contact the local specialist palliative care team for advice.
    - Lorazepam 500mcg – 1mg (1mg tablet supply) S/L PRN (max dose 4mg/day) – regular monitoring as risk of sedation and addiction, seek advice from specialist palliative care team.
    - Avoid fluid overload, consider stopping any clinically assisted (artificial) hydration or nutrition. Suction can be distressing and may not improve respiratory secretions.

### END OF LIFE CARE
- Use of a syringe driver.
- Terminal secretions.
- Agitation.
- Pain.
- Breathlessness.

NB. Sedation and opioid use should not be withheld because of an inappropriate fear of respiratory depression.
COMMUNITY RESPIRATORY TEAM
If not already known to team then refer via CICS, otherwise;

Mon–Fri:9–5pm 020 3317 5355 - answerphone out of hours
Mon–Fri:8–9am, 5–8pm 077 7134 3946 - telephone advice line

Lifestyle adjustments
http://www.macmillan.org.uk/Cancerinformation/Livingwithandaftercancer/Symptomssideeffects/Breathlessness/Managingeverydayactivities.aspx

http://www.macmillan.org.uk/Cancerinformation/Livingwithandaftercancer/Symptomssideeffects/Breathlessness/Goingout.aspx

Depression
http://www.macmillan.org.uk/Cancerinformation/Livingwithandaftercancer/Symptomssideeffects/Breathlessness/Yourfeelings.aspx

Anxiety
http://www.macmillan.org.uk/Cancerinformation/Livingwithandaftercancer/Symptomssideeffects/Breathlessness/Copingwithanxiety.aspx

Cachexia and anorexia

Dry mouth

Breathlessness pharmacological management
http://www.macmillan.org.uk/Cancerinformation/Livingwithandaftercancer/Symptomssideeffects/Breathlessness/Medicinesforbreathlessness.aspx

Supportive and Palliative care IndiCator Tool (SPICT)
http://www.spict.org.uk/the-spict/

References: NICE guidelines [NG31] Care of dying adults in the last days of life
NHS England - Actions for End of Life Care 2014-2016